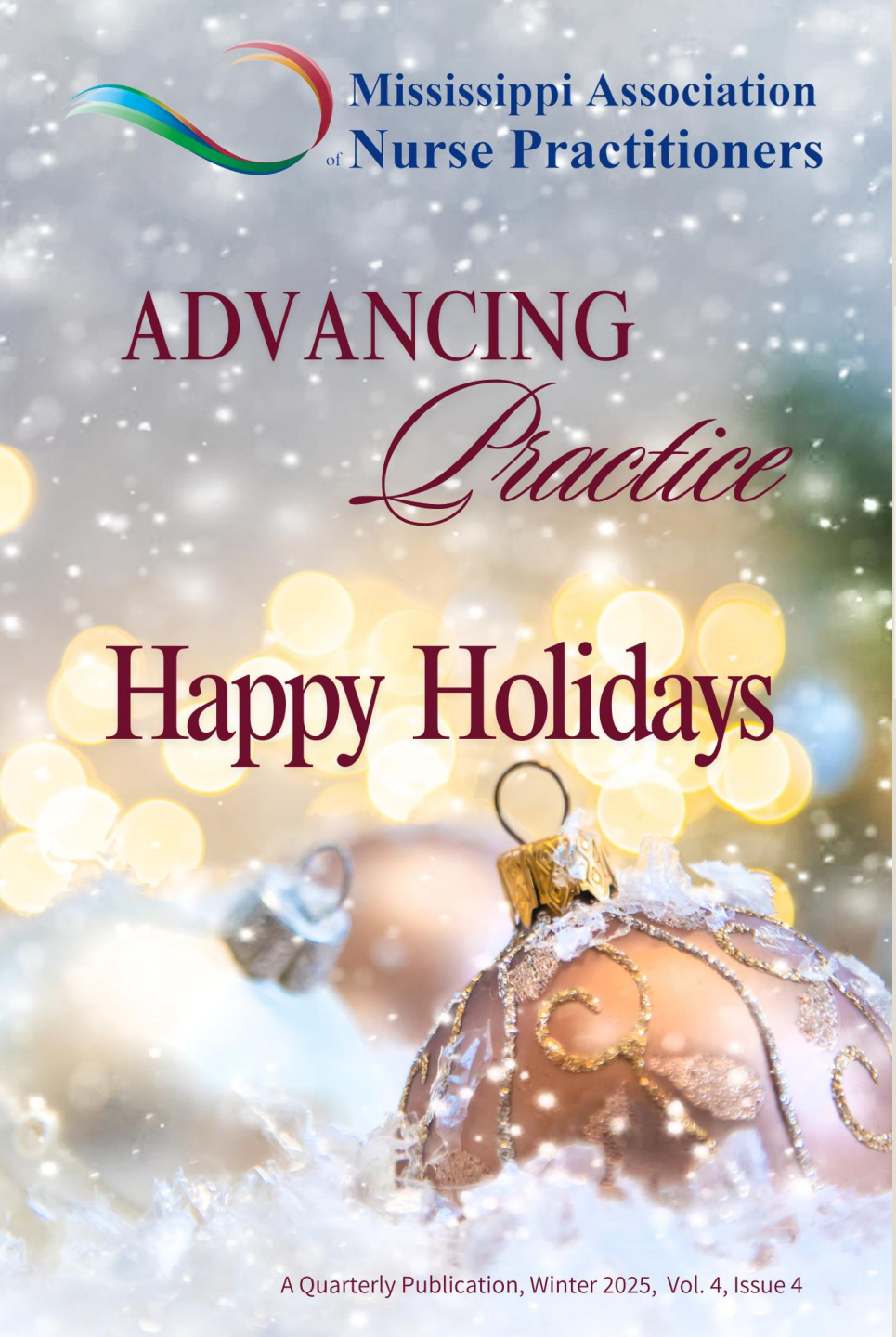
Mississippi Association of Nurse Practitioners

ADVANCING Practice

Happy Holidays



A Quarterly Publication, Winter 2025, Vol. 4, Issue 4

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Membership Options

Annual Membership $300
Monthly Membership (12-payments) $25
NP Student Annual Membership $100
Retired NP Annual (65 +, not in practice) $150
Affiliate membership (Non-NP supporter) $300

Our low membership dues have NOT increased since 2014!

Membership dues go directly to promoting the NP profession. We encourage you to participate actively in your professional specialty organization. We need your help to move your profession forward. Collectively, we can make a difference while protecting the progress we make in Mississippi's healthcare.

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MANP

MISSISSIPPI ASSOCIATION OF NURSE PRACTITIONERS

MS Association of Nurse Practitioners is a non-profit 501 (C)6 professional organization founded in 2014. MANP's mission is to serve as the professional association for Nurse Practitioners of MS. This organization works diligently to provide advocacy, education, and networking to nurse practitioners throughout the state. Our Board is comprised of volunteer nurse practitioners elected by the organization's members. We recognize the importance of NPs in the provision of healthcare, the need for enhanced visibility, and legislative influence at local, state, and federal levels. We provide you with the highest continuing educational opportunities. Our members participate in key NP decision-making roles across the state. Mississippi Association of Nurse Practitioners is *your* specialty association devoted entirely to Nurse Practitioners. Join us today and make a difference in Mississippi.

Contents

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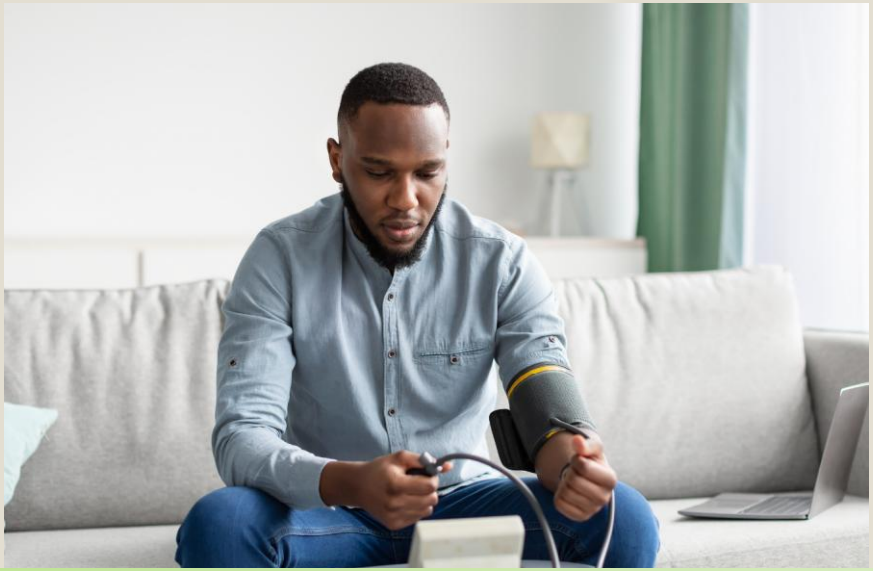

An Initial Review of the Recommendations for the Diagnosis and Management of Hypertension.

By Robert Ware, DNP, MHA, CEN, ACNP-AG, FNP-BC

2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology / American Heart Association Joint Committee on Clinical Practice Guidelines Developed in Collaboration With and Endorsed by American Academy of Physician Associates; American Association of Nurse Practitioners; American College of Clinical Pharmacy; American College of Preventive Medicine; American Geriatrics Society; American Medical Association; American Society of Preventive Cardiology; Association of Black Cardiologists; National Medical Association; Preventive Cardiovascular Nurses Association; and the Society of General Internal Medicine (AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM) retires and replaces the 2017 Guidelines.

Hypertension remains a leading risk factor for cardiovascular disease, stroke, and kidney failure. The 2025 Hypertension Guideline provides updated recommendations for the diagnosis, evaluation, and management of hypertension in adults, reflecting the latest scientific evidence and clinical best practices.

Hypertension is defined as a systolic blood pressure (SBP) ≥130 mm Hg or a diastolic blood pressure (DBP) ≥80 mm Hg, based on multiple readings taken on separate occasions. Blood pressure categories are as follows:

•Normal: SBP <120 mm Hg and DBP <80 mm Hg

•Elevated: SBP 120–129 mm Hg and DBP <80 mm Hg

•Stage 1 Hypertension: SBP 130–139 mm Hg or DBP 80–89 mm Hg

•Stage 2 Hypertension: SBP ≥140 mm Hg or DBP ≥90 mm Hg

When diagnosing hypertension, one should make sure to use accurate measurements by using validated devices and standardized techniques, measure blood pressure in both arms, and use the higher reading, confirm diagnosis with out-of-office measurements (home or ambulatory monitoring, when feasible), assessment of Cardiovascular Risk, evaluate patient history, physical exam, and risk factors (smoking, diabetes, cholesterol, family history) and screen for target organ damage (heart, kidneys, eyes, vascular system). During the initial evaluation, assess for secondary causes of hypertension, and evaluate lifestyle factors (diet, physical activity, alcohol, tobacco). Baseline laboratory tests are important and should include electrolytes, creatinine, fasting glucose, lipid profile, urinalysis, and ECG.

The new guidelines recommend initiation of medication therapy to lower blood pressure as well as lifestyle interventions for all adults with average blood pressure ≥140/90 mm Hg and/or for selected adults with average blood pressure ≥130/80 mm Hg if they individual has clinical cardiovascular disease, history of stroke, diabetes, chronic kidney disease, or increased 10-year predicted cardiovascular risk of ≥7.5% defined by PREVENT™ (Predicting Risk of CVD EVENTs). It is recommended for adults with stage 2 hypertension to initiate antihypertensive drug therapy with 2 first-line agents of different classes in a single pill. The single-pill method is preferred because it is believed that it will improve adherence and reduce time to achieve blood pressure control.

The treatment of special populations must always be considered. In the elderly population, monitor for orthostatic hypotension and individualize goals. In diabetics, ACE inhibitors and ARBs are preferred to achieve a targeted blood pressure of <130/80 mm Hg. In the patient with chronic kidney disease, ACE inhibitors and ARBs are used, but renal function and potassium levels must be monitored. In pregnant patients, Labetalol, Methyldopa, and Nifedipine are the preferred medications. ACE inhibitors, ARBs, and direct renin inhibitors should be avoided.

Patient follow-up and long-term management are important. The patient should adhere to therapy and have regular blood pressure monitoring. There should be periodic evaluation for target organ damage and any other side effects. Providers should continue to emphasize lifestyle modifications and adjust therapy as needed to

achieve and maintain targeted blood pressure.

The 2025 Guidelines are either new or a revision of the 2017 Guidelines. The following is not a comprehensive list of all updates, but a highlight. In terms of terminology, severe hypertension has replaced hypertensive urgency.

New Recommendations include:

1. Secondary Forms of Hypertension, COR 1: In adults with resistant hypertension, screening for primary aldosteronism is recommended regardless of whether hypokalemia is present to increase rates of detection, diagnosis, and specific targeted therapy.

2. Primary Aldosteronism, COR 1: In adults with an indication for screening for primary aldosteronism, it is recommended to continue most antihypertensive medications (other than MRA) before initial screening to minimize barriers to or delays in screening.

3. Lifestyle and Psychosocial Approaches, COR 2a: In adults with or without hypertension, potassium-based salt substitutes can be useful to prevent or treat elevated BP and hypertension, particularly for patients in whom salt intake is related mostly to food preparation or flavoring at home, except in the presence of CKD or use of drugs that reduce potassium excretion, where additional monitoring is probably indicated.

4. Acute Intracerebral Hemorrhage, COR 2a: For adult patients with acute spontaneous ICH who present with SBP between 150 and 220 mm Hg, it can be beneficial to immediately lower SBP to 130 to <140 mm Hg for at least 7 days after ICH to improve functional outcomes, but stop antihypertensive medications if SBP <130 mm Hg.

5. Hypertension and Pregnancy, COR 1: Pregnant individuals with SBP ≥160 mm Hg or DBP ≥110 mm Hg confirmed on repeat measurement within 15 minutes should receive antihypertensive medication to lower BP to <160/<110 mm Hg within 30 to 60 minutes to prevent adverse events.

6. Hypertension and Pregnancy, COR 1: Pregnant individuals with chronic hypertension (defined as pre-pregnancy hypertension or SBP 140-159 mm Hg and/or DBP 90-109 mm Hg before 20 weeks of gestation) should receive antihypertensive therapy to achieve BP <140/90 mm Hg to prevent maternal and perinatal morbidity and mortality.

7. Hypertension and Pregnancy, COR 1: Individuals with hypertension who are planning a pregnancy or who become pregnant should be counseled about the benefits of low-dose aspirin to reduce the risk of preeclampsia and its sequelae.

8. Resistant Hypertension and Renal Denervation, COR 1: In adults with resistant hypertension, a more detailed evaluation for secondary causes, to include careful review of all medications and removal of those with interfering effects on BP, is beneficial for lowering BP and simplifying treatment.

9. Resistant Hypertension and Renal Denervation, COR 1: All patients with hypertension who are being considered for RDN should be evaluated by a multidisciplinary team with expertise in resistant hypertension and RDN.

10. Resistant Hypertension and Renal Denervation, COR 1: For patients with hypertension for whom RDN is contemplated, the benefits of lowering BP and potential procedural risks compared with continuing medical therapy should be discussed as part of a shared decision-making process to ensure patients choose the therapy that meets their expectations.

11. Hypertensive Emergencies and Severe Hypertension for Nonpregnant and Nonstroke Patients, COR 3 Harm: For adults with severe hypertension (>180/120 mm Hg) who are hospitalized for noncardiac conditions without evidence of acute target organ damage, intermittent use of additional intravenous or oral antihypertensive medications is not recommended to acutely reduce BP.

Revised from the 2017 Guidelines:

1. Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension. (2017) COR 1: Use of BP-lowering medications is recommended for secondary prevention of recurrent CVD events in patients with clinical CVD and an average of SBP ≥130 mm Hg or an average DBP ≥80 mm Hg and for primary prevention in adults with an estimated 10-year ASCVD risk of ≥10% and an average SBP ≥130 mm Hg or an average DBP ≥80 mm Hg. (2025) COR 1: In adults with hypertension without clinical CVD but with diabetes or CKD or at increased 10-year CVD risk (ie, ≥7.5% based on PREVENT), initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg and average DBP is ≥80 mm Hg to reduce the risk of CVD events and total mortality.

2. Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension. (2017) COR 1: Use of BP-lowering medication is recommended for primary prevention of CVD in adults with no history of CVD and with an estimated 10-year ASCVD risk <10% and an SBP ≥140 mm Hg or a DBP ≥90 mm Hg. (2025) COR 1: In adults with hypertension without clinical CVD and with estimated 10-year CVD risk <7.5% based on PREVENT, initiation of medications to lower BP is recommended if average SBP remains ≥130 mm Hg or average DBP remains ≥80 mm Hg after a 3- to 6-month trial of lifestyle intervention to prevent target organ damage and mitigate further increases in BP.

3. Diabetes. (2017) COR 2b: In adults with diabetes and hypertension, ACEi or ARB may be considered in the presence of albuminuria. (2025) COR 1: In adults with diabetes and hypertension, ACEi or ARB are recommended in the presence of CKD as identified by eGFR <60 mL/min/1.73 m2 or albuminuria ≥30 mg/g and should be considered when mild albuminuria (<30 mg/g) is present to delay progression of diabetic kidney disease.

4. Hypertension Treatment in Patients With Chronic Kidney Disease. (2017) COR 2a: In adults with hypertension and CKD (stage 3 or higher or stage 1 and 2 with albuminuria ≥300 mg/d, or ≥300 mg/g albumin-to-creatinine ratio or the equivalent in the first morning

void), treatment with an ACEi is reasonable to slow kidney disease progression. AND COR 2b: In adults with hypertension and CKD (stage 3 or higher or stage 1 and 2 with albuminuria ≥300 mg/d, or ≥300 mg/g albumin-to-creatinine ratio or the equivalent in the first morning void), treatment with an ARB may be reasonable if an ACEi is not tolerated. (2025) COR 1: For adults with hypertension and CKD as identified by eGFR <60 mL/min/1.73 m2 with albuminuria of ≥30 mg/g, RAASi (either with ACEi or ARB but not both) is recommended to decrease CVD and delay progression of kidney disease.

5. Acute Intracerebral Hemorrhage. (2017) COR 2a: In adults with ICH who present with SBP >220 mm Hg, it is reasonable to use continuous intravenous drug infusion and close BP monitoring to lower SBP. (2025) COR 2a: In adults with acute spontaneous ICH requiring acute BP lowering, careful titration to ensure smooth, nonlabile, and sustained control of BP, avoiding peaks and large variability in SBP, can be beneficial for improving functional outcomes.

6. Acute Ischemic Stroke. (2017) COR 3 Harm: Immediate lowering of SBP to <140 mm Hg in adults with spontaneous ICH who present within 6 hours of the acute event and have an SBP between 150 and 220 mm Hg is not of benefit to reduce death or severe disability and can potentially be harmful. (2025) COR 3 Harm: In patients undergoing successful brain reperfusion with endovascular treatment for a large vessel occlusion, lowering SBP <140 mm Hg within the first 24 to 72 hours after reperfusion can worsen long-term functional outcome.

7. Mild Cognitive Impairment and Dementia. (2017) COR 2a: In adults with hypertension, BP lowering is reasonable to prevent cognitive decline and dementia. (2025) COR 1: In adults with hypertension, a goal of <130 mm Hg SBP is recommended to prevent mild cognitive impairment and dementia.

8. Hypertension and Pregnancy. (2017) COR 3 harm: Women with hypertension who become pregnant should not be treated with ACEi or direct renin inhibitors. (2025) COR 3 Harm: Individuals with hypertension who are planning a pregnancy or who become pregnant should not be treated with atenolol, ACEi, ARB, direct renin inhibitors, nitroprusside, or MRA to avoid fetal harm.

The 2025 Hypertension Guideline emphasizes the importance of early detection, accurate diagnosis, and a combination of lifestyle and pharmacological interventions to manage hypertension and reduce associated health risks effectively. Individualized care and regular follow-up are essential for optimal outcomes.

The guidelines were evidence-based when possible. It is important to understand the class (strength) of the recommendations and the level (quality) of evidence.

References

AHA/ASA H Journals. (2024, August 14). AHA / ACC / AANP / AAPA / ABC / ACCP / ACPM / AGS / AMA/ ASPC / NMA / PCNA / SGIM guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: A report of the American College of Cardiology / American Heart Association joint committee on clinical practice guidelines.
Https://www.ahajournals.org/doi/10.1161/CIR.0000000000001356#T1

https://www.ahajournals.org/doi/epub/10.1161/CIR.0000000000001396

Class (Strength) of Recommendation

Class 1 (STRONG) — *Benefit >>>Risk*
Suggested phrases for writing recommendations:
1.Is recommended
2.Is indicated/useful/effective/beneficial
3.Should be performed/administered/other
4.Comparative-Effectiveness Phrases
*treatment/strategy A is recommended/indicated in preference to treatment B
*Treatment A should be chosen over treatment B.

Class 2a (MODERATE) — *Benefit >>Risk*
Suggested phrases for writing recommendations:
1.Is reasonable
2.Can be useful/effective/beneficial
3.Comparative-Effective Phrases
*Treatment/strategy A is probably recommended/indicated in preference to treatment B
*It is reasonable to choose treatment A over treatment B

Class 2b (WEAK) — *Benefit >/= Risk*
Suggested phrases for writing recommendations:
1.May/might be reasonable
2.May/might be considered
3.Usefulness/effectiveness is unknown/unclear/uncertain or not well-established

Class 3: No Benefit (MODERATE) — *Benefit = Risk*
(Generally, LOE A or B use only)
Suggested phrases for writing recommendations:
1.Is not recommended
2.Is not indicated/useful/effective/beneficial
3.Should not be performed/administered/other

Class 3: HARM (STRONG) — *Risk > Benefit*
Suggested phrases for writing recommendations:
1.Potentially harmful
2.Causes harm
3.Associated with excess morbidity/mortality
4.Should not be performed/administered/other

Photo Credit: submitted by author

Robert Ware, DNP, MHA, CEN, ACNP-AG, FNP-BC

Dr. Robert Ware is the Director of Operations for the Mississippi Baptist Hospitalist Program, which employs 33 hospitalists, 2 Neuro-Hospitalist, 14 nurse practitioners, and 4 RNs. Dr. Ware serves as Adjunct Faculty at Baptist Health Science University in the Acute Care Nurse Practitioner Program. Dr. Ware is a MANP charter board member and has served as President, Vice-President, and Treasurer.

National Multiple Sclerosis Society

Multiple Sclerosis Rural Health Fact Sheet


Jovany (right), diagnosed in 2016


Suni, diagnosed in 2018


Donna, diagnosed in 1989

Rural Health and MS

Multiple sclerosis (MS) is a chronic, inflammatory disease that involves immune-mediated attacks on the central nervous system. It is characterized by relapses and remissions of neurological symptoms and progression of functional disability over time. Abnormal immune activity creates inflammation and damages myelin sheaths, axons and oligodendrocytes.

Only 13% of those living in rural counties have full access to neurology care, and 83% living in rural areas live in MS specialist deserts. It is critical that rural health professionals recognize the early signs and symptoms of MS because early diagnosis changes the MS journey to allow for earlier treatment and better prognosis.

13% have full access to neurology care

83% live in MS specialist deserts

While MS is 3x more common in women, people of all genders get MS.

Most people are diagnosed between the ages 20–50.

Nearly 1 million people live with MS in the United States.

Etiology

While the **cause of MS is unknown**, the interaction of environmental (e.g., smoking, low vitamin D, obesity, Epstein-Barr virus exposure), familial and genetic factors may trigger immune dysregulation and contribute to a person's risk of developing the disease. People of all racial and ethnic groups can develop MS.

Signs and Symptoms Consistent With MS

MS symptoms develop over hours to days and are usually constant for days to weeks.

- **Visual:** optic neuritis, blurred or double vision, unilateral vision loss, nystagmus
- **Motor:** trunk/extremity weakness, spasticity, hyperreflexia, gait disturbance, imbalance
- **Sensory:** numbness, burning, tingling, Lhermitte's sign, squeezing around torso, trigeminal neuralgia
- **Cerebellar:** tremor, ataxia, incoordination
- **Bladder and Bowel Dysfunction:** urinary frequency, urgency or retention, incontinence, frequent UTI, and constipation
- **Mood and Cognition:** depression, anxiety or impairment of memory, attention, concentration or information speed processing

As a first point of contact, you can help recognize the early signs and symptoms and make an MRI and neurology referral. Treating MS early reduces the burden of injury and disease progression. Find healthcare professionals with expertise in diagnosing and treating MS: **nationalMSsociety.org/FDR.**

Diagnosis

MS diagnosis:

- Medical history and clinical examination
- Paraclinical tests, with or without clinical symptoms
- Elimination of more likely diagnoses (no better explanation)

Paraclinical tests:

- Magnetic resonance imaging
- Optical coherence tomography and visual evoked potential
- Serum and spinal fluid analysis

View the diagnostic criteria and workup

nationalmssociety.org/DiagnosticCriteriaWorkup

Treatment

- Management of MS across the lifetime requires a comprehensive and holistic approach, including disease modifying therapy (DMT), rehabilitation, specialty care and lifestyle management interventions.
- Initiating a DMT as soon as possible after diagnosis is critical. There is a large body of evidence that shows early and ongoing treatment with a DMT reduces the frequency of relapses, delays disease progression and minimizes the risk of irreversible disability.
- Relapses can be treated with high-dose glucocorticoids.
- Symptoms can be managed with medications and non- pharmacological strategies, like PT/OT, cognitive behavioral therapy and speech and language therapy.

Lifestyle Interventions and Preventive Health Measures

- **Educate on modifiable risk factors**
  - » Smoking cessation
  - » Monitoring vitamin D level to ensure an optimal level is obtained
  - » Whole food diet — colorful fruits, vegetables, lean meat/seafood, whole grains
  - » Regular exercise routine — combination of aerobic, strength and stretching activity
  - » Stress reduction — meditation, mindfulness, breathing techniques
  - » Healthy sleep hygiene
  - » Social support and connection
- **Maintain consistent primary care engagement**
  - » Most people with MS live normal lifespans.
  - » Management of disease complications or comorbidities is essential and requires consistent primary care engagement.

Resources and Support

nationalMSsociety.org/PRC

nationalMSsociety.org/nrha

National Multiple Sclerosis Society

nationalMSsociety.org

1-800-344-4867

Updated 9/2025

Why the 75-mile physician rule restricts patient care.

Access denied: Why the 75-mile radius rule restricts patient care

Here in Mississippi, access to primary care remains one of the most significant gaps in our state's broken healthcare system. As the days pass, more rural, critical access hospitals continue to close, leaving thousands of Mississippians living in underserved areas, or healthcare deserts. Despite these harrowing realities, current laws and regulations in the state continue to limit nurse practitioners from practicing to the full extent of their education and training.

According to the Mississippi State Board of Medical Licensure (2021), for a practitioner to perform the duties of their day-to-day job, they must not only have a collaboration agreement in place with a physician, but the practitioner must also remain within a seventy-five-mile radius of the physician to practice. This policy not only prohibits the practitioner, despite their years of practice experience, from practicing independently, but also imposes geographical limitations on them. While viewed from a theoretical standpoint, this policy was intended to facilitate physician oversight; however, it restricts access to care. There are many areas in the state where an appropriate collaborator is not available within a seventy-five-mile radius. As a result, many specially trained practitioners, such as women's health and psychiatric practitioners, are unable to practice, leaving many Mississippians without vital healthcare in areas like the Mississippi Delta and Pine Belt regions. Due to these restrictions, many residents are required to travel great distances or wait prolonged periods to see providers who are already overwhelmed and overbooked with an excessive number of patients.

According to multiple agencies, the nurse practitioner profession is one of the fastest-growing professions in the country. However, antiquated policies in many states continue to restrict their value to the healthcare system, especially in Mississippi, where gaps in healthcare have created significant disparities leaving the state one of the least healthy in the nation. Because of these disparities, Mississippi should follow the lead of 27 other states in the country and allow practitioners Full Practice Authority. Under this updated legislative provision, practitioners will be allowed to work to their fullest educational and training extent without the need for a collaboration agreement or the seventy-five-mile rule. While many individuals advocate for this, some oppose full practice. Many believe that all practitioners should be granted full practice, while others believe that full practice should be allowed after a regulatory transition period of three to five years, during which collaboration is required. There are some who believe this policy has some benefits that include physician oversight for not only new practitioners, but all practitioners, regardless of years of practice, and gives some reassurance for those who oppose full practice authority measures. However, this policy, along with restricted practice legislation, does come with its fair share of downfalls, which include limitations to access of care, unnecessary economic barriers placed on practitioners, antiquated and inefficient healthcare hierarchies, and contribute to longer wait times for patients to receive care. Multiple studies have been completed in

The past demonstrates that the care provided by practitioners is equal to, if not better than, that of some physician counterparts in certain metrics. The states that have removed these barriers have shown an increase in preventative services, lower healthcare costs, and a decrease in patient wait times.

The seventy-five-mile policy and restricted practice legislation were created to ensure practitioners receive the appropriate oversight per the medical board. However, these policies create limited practitioner oversight by physicians and have created a barrier to care. With modern healthcare turning to cloud-based health records systems that can be accessed from any location and at any time. The mileage rule for collaboration should be overturned and abolished. Other restrictive practice states only require that the collaborator be licensed in the state where the practitioner is practicing and have no limitation on mileage. By overturning both the mileage regulations and permitting full practice authority, many of Mississippi's healthcare gaps can and will be addressed, if not completely closed. Access to care should not depend solely on an arbitrary mileage regulation and should be available to all Mississippi residents, regardless of where they reside. It is time for Mississippi to catch up with the modern world of healthcare and allow practitioners to practice to their fullest educational and trained extent to provide safe and quality care to all, not just those who live in urban and suburban areas of the state.

References

Mississippi Board of Medical Licensure. (2021). Collaborative practice agreements: Rules and regulations. Retrieved on 5, October, 2025, from https://www.msbml.ms.gov/sites/default/files/Rules_Laws_Policies/6-2025Administrative%20Code.pdf

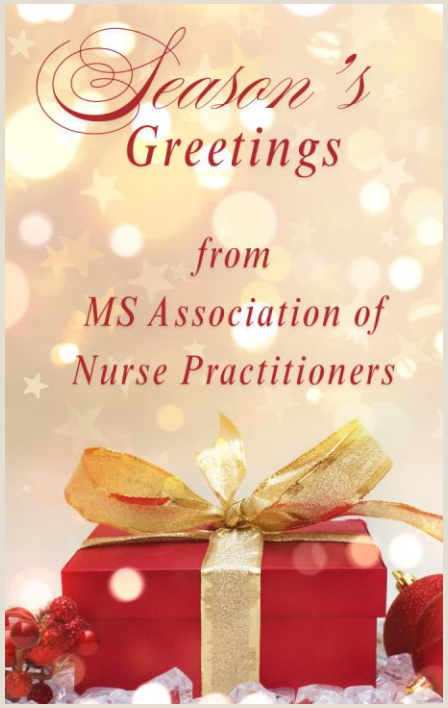

Photo Credit: submitted by author

Kent Hawkins, MSN, FNP-BC, DNP©

Kent Hawkins is the Vice President of the Mississippi Association of Nurse Practitioners and Co-owner of Family Care Clinic in Hernando, Mississippi. He is currently pursuing a Doctor of Nursing Practice (DNP) degree at Mississippi University for Women in Columbus. Kent earned his Master of Science in Nursing (MSN) with a Family Nurse Practitioner concentration from the University of Memphis Loewenberg College of Nursing in 2017. He completed his Bachelor of Science in Nursing (BSN) at Baptist College of Health Sciences in Memphis, Tennessee, in 2013, and his Associate Degree in Nursing (ADN) from Northwest Community College in Senatobia, Mississippi, in 2009.

Job Postings

Medical Summary Reviewer

Setting: remote

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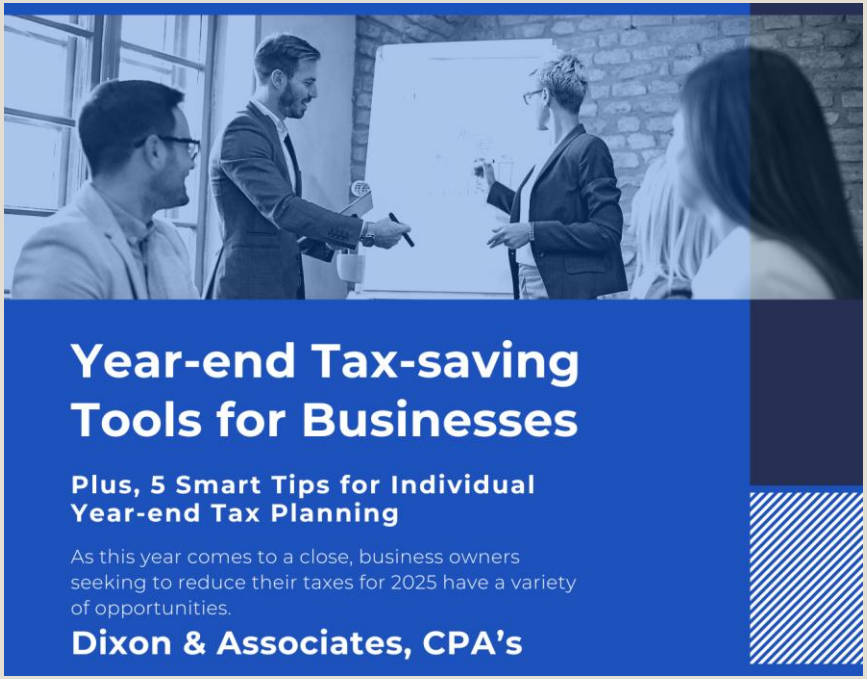
Organization:
Medsync Corp

Mailing Address:
3540 Toringdon Way, Suite 200
Charlottle NC 28277

Contact Person:
Matthew Trotta

Phone: 513-581-0368

Email:
info@medsyncorp.com



As this year comes to a close, business owners seeking to reduce their taxes for 2025 have a variety of opportunities. Here's a look at two tax-saving tools: bonus depreciation and retirement plan contributions.

Assets eligible for bonus depreciation

First-year bonus depreciation has been given new life under the legislation commonly known as the "One Big Beautiful Bill Act" (OBBBA). It had been scheduled to be only 40% for 2025 (60% for certain long-production assets) and to vanish after 2026. The OBBBA permanently reinstates 100% bonus depreciation for

The eligible assets acquired and placed in service after January 19, 2025. Acquiring eligible assets and placing them in service by Dec. 31, 2025, could significantly reduce your 2025 tax liability.

Eligible assets include most depreciable personal property, such as:

•Equipment,
•Computer hardware and peripherals,
•Certain vehicles, and
•Commercially available software.

Also eligible is qualified improvement property (QIP), defined as improvements to the interior of a nonresidential building that was already placed in service. QIP doesn't include costs to change the building's internal structural framework (such as enlargement). These costs must generally be depreciated over 39 years.

Unlike Section 179 expensing, which is limited to $2.5 million for 2025 (up from $1.25 million before the OBBBA) and subject to a phaseout, the amount of bonus depreciation a taxpayer can claim is generally unlimited. But there are other tax consequences to consider.

Beware of the excess business loss rule

Individual taxpayers who have losses as a sole proprietor or as an owner of a pass-through entity (partnerships, S corporations, and generally, limited liability companies) may inadvertently trigger the excess business loss rule when they claim bonus depreciation. The excess business loss rule allows business losses to offset income from other sources (such as salary, self-employment income, interest, dividends, and capital gains) only up to an annual limit. Amounts above that limit are excess business losses. For 2025, this is the excess of aggregate business losses over $313,000 ($626,000 for married couples filing jointly).

Excess business losses can't be deducted in the current year and must be carried forward to the following tax year. Such losses can then be deducted under the rules for net operation loss carryforwards. As a result, an individual taxpayer's 100% first-year bonus depreciation deduction can effectively be limited by the excess business loss rule.

Save taxes by saving for retirement

Tax-favored retirement plans can provide significant savings for small business owners, both by building retirement security and by reducing taxes. Contributions are tax-deductible (or pre-tax, if you're contributing as an employee).

One of the simplest options is a Simplified Employee Pension (SEP) IRA. If you're self-employed, you can contribute up to 20% of your net income to a SEP IRA, with a cap of $70,000 for the 2025 tax year. If your own corporation employs you, the contribution limit is 25% of your salary, also capped at $70,000. The tax savings can be substantial.

Other options include 401(k)s, SIMPLE IRAs, and defined benefit plans. Depending on your age and income, some of these options might allow you to make even larger contributions. Ask your tax advisor for details.

Wrapping it up

The permanent restoration of 100% first-year bonus depreciation creates tax-saving opportunities for taxpayers while they expand their business potential. And a tax-favored retirement plan is beneficial for you, your business, and your employees. Every business is different, so it's essential to consult a tax professional. Contact the office for help tailoring your tax strategies for 2025 and beyond.

5 Smart Tips For Individual Year-end Tax Planning

Even during the last two months of the year, you can take steps to reduce your 2025 tax liability. Here are five practical strategies to consider.

1. Use bunching to maximize deductions

If your itemized deductions are close to the standard deduction, consider a "bunching" strategy. This means timing certain payments (such as mortgage interest, state and local taxes, charitable gifts, and medical expenses) so that they push you above the standard deduction in one year. The following year, you can take the standard deduction and, to the extent possible, defer paying deductible expenses to the following year. This alternating approach helps you capture deductions that might otherwise be lost.

2. Balance gains and losses

If you have investments in taxable accounts, keep an eye on both realized and unrealized gains and losses. Selling appreciated securities held for more than a year ensures they're taxed at your lower long-term capital gains rate (typically 15% or 20%, plus the 3.8% net investment income tax at higher income levels), rather than your higher, ordinary-income rate (which may be as much as 37%). But selling investments at a loss can offset gains. If losses exceed gains, up to $3,000 can offset ordinary income, with the remainder carried forward. This flexibility can reduce taxes this year and in future years.

3. Gift appreciated assets to loved ones

If you want to support family members while cutting your tax bill, consider giving appreciated investments to adult children or other relatives in lower tax brackets. They can sell the assets at a lower capital gains rate, possibly even 0%. Just be cautious about the "kiddie tax," which generally applies to children under age 19 (24 if they're a full-time student), and potential gift tax implications.

4. Give wisely to charities

Instead of donating cash, consider giving highly appreciated stock or mutual fund shares that you've held more than one year. You avoid owing capital gains tax and can deduct the full fair market value if you itemize. Alternatively, selling investments at a loss and donating the proceeds allows you to claim both the capital loss and the charitable deduction. With some tax rules set to tighten in 2026, making larger gifts before year-end could be especially advantageous. (But if you don't itemize, you can look forward to the limited charitable deduction that will be available to non-itemizers beginning in 2026.)

5. Use your IRA for donations

For those age 70½ or older, making charitable donations directly from an IRA, called "qualified charitable distributions" (QCDs), offers unique advantages. You can donate up to $108,000 in 2025 directly to qualified charities, keeping those amounts out of your taxable income. This strategy reduces adjusted gross income, which may help preserve eligibility for other tax breaks.

Final thought

The best tax strategies depend on your personal situation. Timing, income level and future expectations all matter. Before taking action, contact the office to tailor these approaches to your needs.

Visit Our Website: www.dixoncpafirm.com

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Carlton Dixon
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408 W Main Street
Senatobia, MS 38668

For years, Dixon & Associates has been providing quality, personalized financial guidance to local individuals and businesses. Our expertise ranges from basic tax management and accounting services to more in-depth services, such as financial statements and financial planning.

Dixon & Associates is one of the leading firms in North Mississippi. By combining our expertise and experience, we guarantee every client receives the close analysis and attention that they deserve. Our dedication to high standards and work ethic is the reason our client base returns year after year.

Hernando, MS, Family Care Clinic Celebrates Ribbon Cutting & Grand Opening

– August 8, 2025 –

Family Care Clinic, located at 2170 Highway 51 South, proudly celebrated its Ribbon Cutting and Grand Opening on Friday, August 8, 2025. The clinic is co-owned by Tiffany Houston and Kent Hawkins, both Family Nurse Practitioners from the Senatobia area, along with third co-owner, Josh Hammons. Family Care Clinic is dedicated to providing comprehensive, patient-centered healthcare to individuals and families throughout the Hernando community. “We are thrilled to open our doors and begin serving the residents of Hernando,” said co-owner Tiffany Houston, FNP. “Our goal is to deliver compassionate, high-quality care in a welcoming environment.” The ribbon-cutting ceremony was attended by local officials, community members, friends, family, and representatives from the Hernando Chamber of Commerce, marking the beginning of a new chapter in accessible family healthcare for the area.

Member Spotlight

Tiffany Houston, MSN, FNP-BC

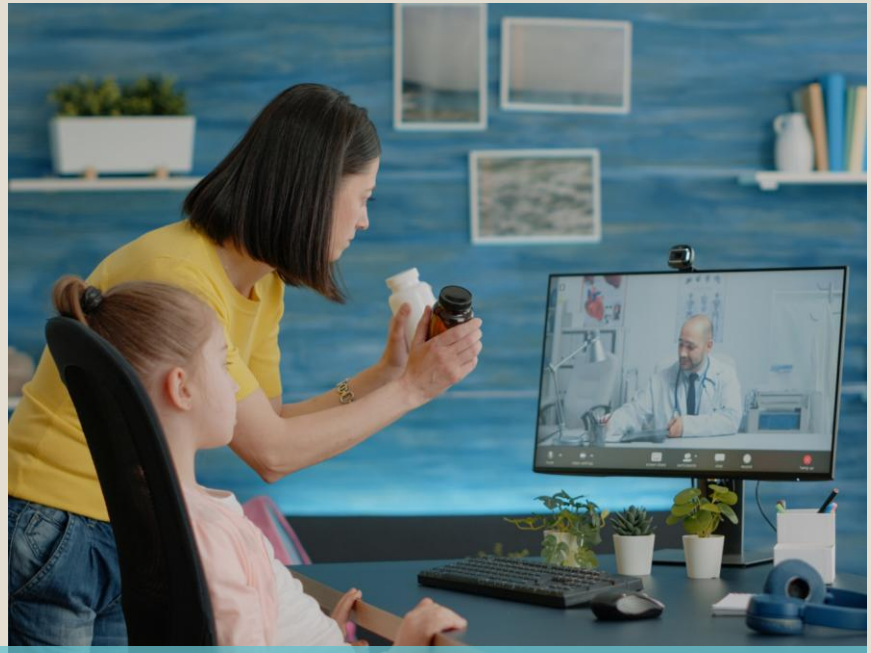
Tiffany Houston is a board-certified Family Nurse Practitioner and one of the proud owners of Family Care Clinic. She was born in Memphis, TN, but moved to Louisiana shortly thereafter. She learned the values of compassion, hard work, and perseverance, which continue to guide her today. In 1995, she moved to Senatobia, MS, met my husband of 20 years, started a family, and now calls home.

She is a 1999 graduate of Magnolia Heights School in Senatobia. She began her nursing career in 2012 as an LPN and earned an Associate Degree in Nursing in 2016 from Northwest Community College in Senatobia. Her passion for learning and desire to improve patient care led her to pursue advanced education. She proudly achieved a Master’s Degree in Nursing in 2024.

Her previous nursing experience includes Wound care, Cardiac Cath Lab, Nursing home care, Home Health Care, Emergency Department, ICU step-down, and Nursing Education. Nursing has always been more than just a career for Tiffany—it’s a calling. Caring for others and helping them achieve better health has been a lifelong passion.

From the beginning of her journey in healthcare, she dreamed of one day opening a clinic where she could provide compassionate, patient-centered care to families in her community. That dream became a reality with the opening of Family Care Clinic in Hernando.

Tiffany states, “My goal is to create a welcoming environment where individuals and families feel heard, cared for, and supported in their health and wellness journeys. I am deeply grateful for the experiences that have shaped me, the community that supports me, and the opportunity to live out my dream of making a meaningful difference in the lives of others.”



Telehealth Access Changes as of October 1, 2025

Telehealth Access Guidance and Medicare Flexibilities

Congressional Legislation extended Medicare telehealth that was in place due to the COVID pandemic through September 30, 2025. These regulations did not receive legislative action and, therefore, were not extended past the September deadline date. Mississippi Association of Nurse Practitioners, along with many others, wrote letters supporting the continuation for telehealth. After the September 30, 2025, deadline, except for behavioral health services, beneficiaries will generally need to be in a medical facility and in a rural area to receive Medicare telehealth services.

Any behavioral health service furnished by an RHC or FQHC on or after January 1, 2022, through telecommunications technology is paid under the All Inclusive Rate (AIR) and Prospective Payment System (PPS), respectively. Through December 31, 2025, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through telecommunications technology by reporting HCPCS code G2025 on the claim. According to MLC Connects Newsletter for October 21, 2025, if a beneficiary began receiving mental health services on or before September 30, 2025, they would not be required to have an in-person visit within 6 months; instead, they would be considered established and would be required to have at least one in-person visit every 12 months. CMS further explains that Non-behavioral/mental telehealth services in Medicare can be delivered using audio-only communication platforms through September 30, 2025. Interactive telecommunications system may also permanently include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. Physicians and/or practitioners should use POS 02 for *Telehealth Provided Other than in Patient's Home* or POS 10 for *Telehealth Provided in Patient's Home*.

CMS instructed all Medicare Administrative Contractors (MACs) to lift the claims hold and process claims with dates of service of October 1, 2025, and later for certain services impacted by select expired Medicare legislative payment provisions passed under the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119-4, Mar. 15, 2025). In the MLN Connects Newsletter for October 21, 2025, CMS recommends that Practitioners should monitor Congressional action and may choose to hold claims associated with telehealth services that are currently not payable by Medicare in the absence of Congressional action. For further information: https://www.cms.gov/medicare/coverage/telehealth.

For more information, including information on to which ACOs these flexibilities apply: https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf (PDF).

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https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates

https://www.cms.gov/medicare/coverage/telehealth

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Melvin Smith, MPH, MSU Graduate Assistant

Rural America continues to face disproportionate health risks caused by barriers like provider shortages and limited access to care. Among these are agricultural families—individuals whose daily lives are deeply connected to farm work. While cultural understanding addresses many demographic factors, few healthcare professionals are trained in the occupational aspects of rural life. To address this gap, Mississippi State University Extension launched the Agriculture Family Friendly Training and Designation (AFTD) Program, a continuing education effort aimed at increasing healthcare professionals' awareness of the agricultural context in rural health. Developed with support from the Mississippi Association of Nurse Practitioners (MANP) and other partners, AFTD provides practitioners with the cultural and contextual knowledge necessary to offer compassionate care to farm families throughout Mississippi and beyond.

Understanding the Agricultural Context of Rural Health

Traditional clinical education often views rural health mainly through geography, such as distance to hospitals, provider shortages, or telehealth logistics. What remains largely unseen is the agricultural identity that characterizes many rural patients. Farmers and farming workers face a unique set of stressors: unpredictable markets, weather-dependent income, physical labor, and strong psychological ties to their land. The AFTD program introduces healthcare providers to these realities as important cultural factors affecting health. Ideas like the "farmer-land bond" and the cyclical nature of agricultural stress are examined along with communication methods that honor the autonomy and pride ingrained in farming culture. By presenting these factors as crucial parts of patient-centered care, the program helps clinicians bridge a long-standing cultural gap between urban-trained providers and the rural patients they serve.

A Curriculum Rooted in Experience and Evidence

Based on the Cooperative Extension's Framework for Health Equity and Well-Being, the AFTD program incorporates adult learning theory and public health systems thinking to prepare those who provide direct patient care. Each of the five modules in the course is designed for practical application. Participants work through case scenarios and reflective exercises that challenge assumptions and promote culturally sensitive approaches. The training is approved for one Continuing Medical Education (CME) credit by the Accreditation Council for Continuing Medical Education (ACCME).

Early Outcomes and Lessons Learned

Since its launch in early 2025, the AFTD program has shown strong potential for impact. From January to August 2025, the course enrolled

44 participants, with notable growth following outreach partnerships with partner organizations. Participants have included not only physicians and nurses but also social workers, community health workers, and mental health practitioners.

Feedback from participants has highlighted immediate usefulness in practice. Many mentioned the benefit of understanding rural patient

decision-making and the importance of framing care discussions around agricultural routines. Others valued how the modules humanized rural patients' experiences, turning what might seem like logistical issues into relational opportunities for better care.

Encouraged by early success, the MSU Extension team will relaunch the AFTD program between March and June 2026. The updated version will include American Nurses Credentialing Center (ANCC) credits for accreditation and add more applied learning scenarios based on partner feedback.

We are always discussing exploring the barriers and supports of the program and how the training has influenced their approach to patient care.

Contact graduate assistant Melvin Smith at mls560@msstate.edu for more information.

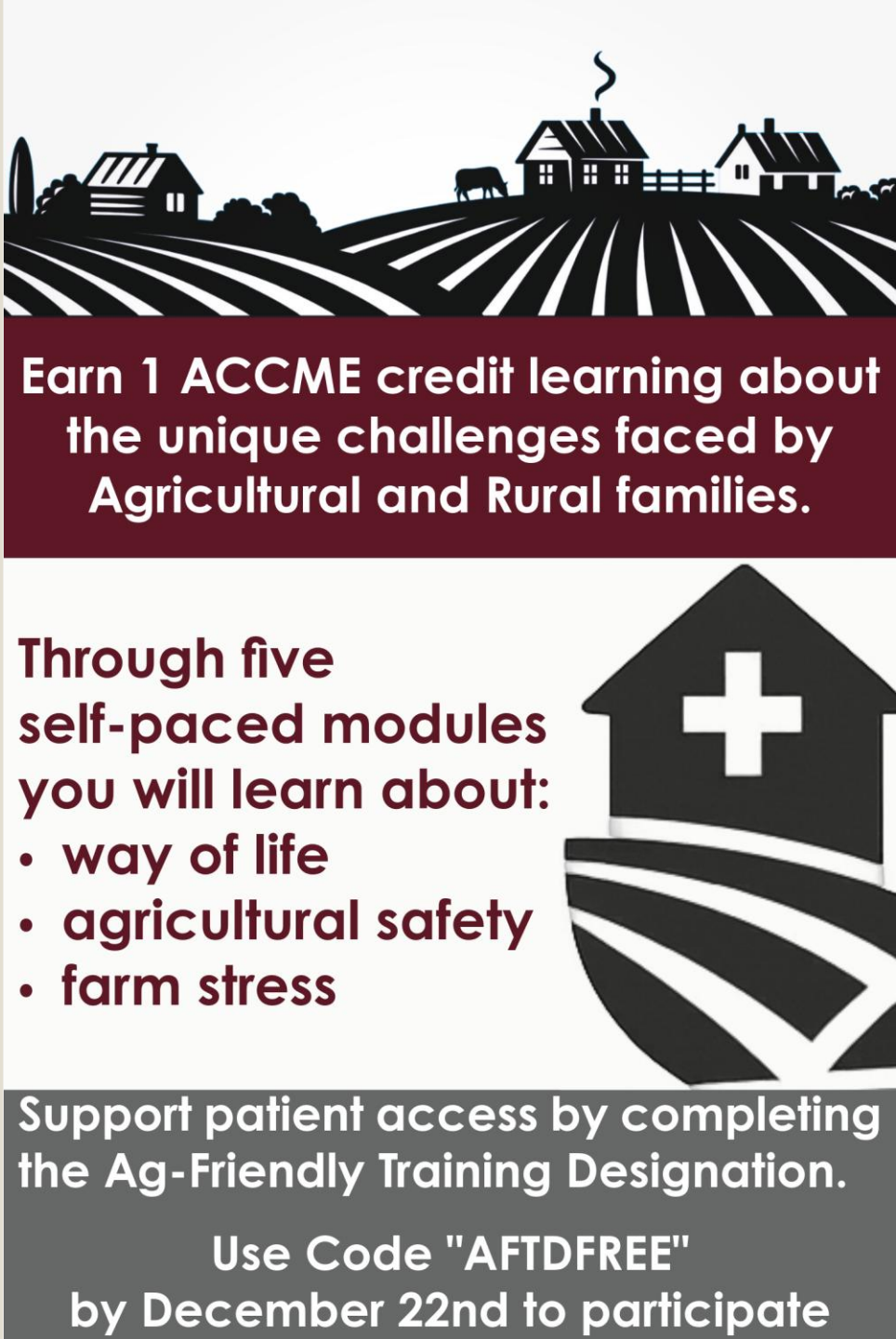
Use code "AFTDFREE" and this link to enroll with free access until December 22nd, 2025.

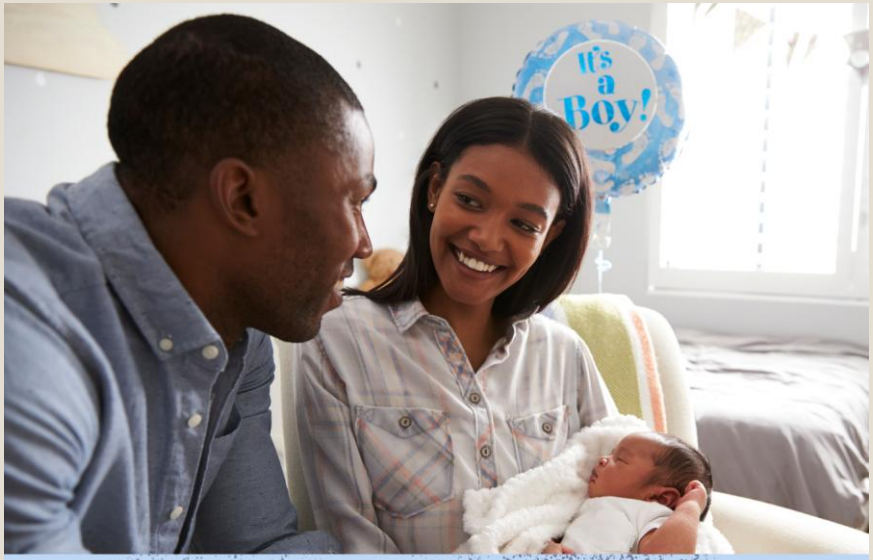
https://reg.extension.msstate.edu/reg/event_page.aspx?ek=0081-0004-7947803c2fc147ee9467d301da20c090

Photo Credit; submitted by author

Melvin L. Smith Jr., MPH

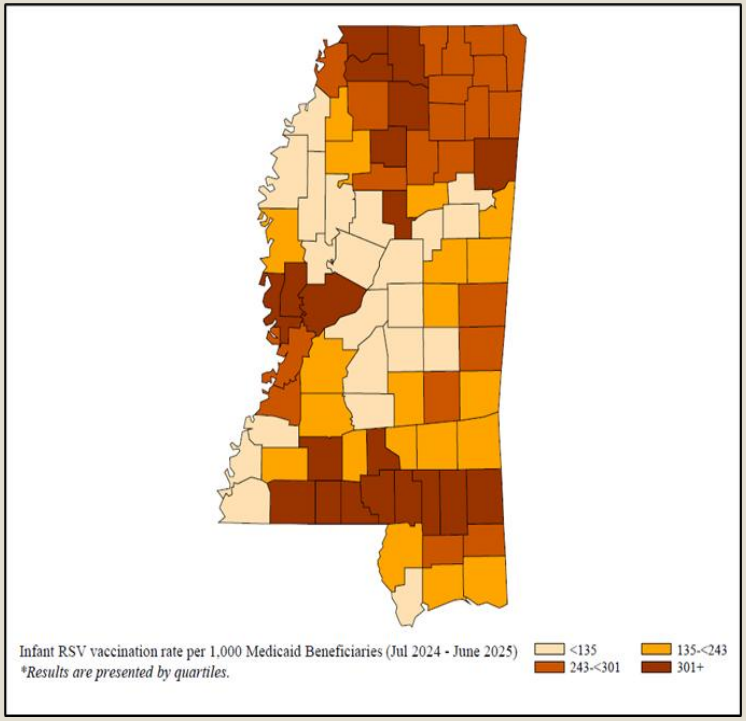
Melvin L. Smith Jr., MPH, is a doctoral student in Instructional Systems and Workforce Development at Mississippi State University. His research examines how technology, mentorship, and program design can improve access to workforce opportunities. Professionally, Melvin has worked across healthcare policy, IT operations, and higher education, focusing on building systems that connect institutional goals with community needs. His work emphasizes education as infrastructure and centers on developing pathways that support economic mobility for community populations.





Protecting Mississippi Babies from Respiratory Syncytial Virus: What Nurse Practitioners Need to Know

Mississippi Medicaid shares updated data and opportunities



How Mississippi Infants Were Protected Last Season

During the 2024–2025 season, Mississippi Medicaid reviewed RSV protection for infants born between March 2024 and March 2025. A total of 25,031 infants were eligible to receive protection during their first RSV season.

- 5,097 infants received Beyfortus® (nirsevimab)
- 401 infants received passive protection through maternal RSV vaccination (Abrysvo®)
- Overall protection reached 22%, up from approximately 10% the previous season

This improvement shows meaningful progress, but many infants across Mississippi still lack protection from RSV.

Where Protection Rates Are Lowest

Some counties continue to have lower RSV protection rates and may benefit from targeted outreach and additional provider engagement.

How Nurse Practitioners Can Make a Difference

Nurse practitioners play a critical role in increasing RSV protection across the state.

As we approach the 2025–2026 season, NPs can help by:

- Discussing RSV prevention with all pregnant patients
- Ensuring infants receive Beyfortus® or Enflonsia® early in the RSV season
- Reinforcing vaccine and antibody safety during patient counseling
- Helping families understand timing and eligibility during prenatal, newborn, and well-child visits

Clinical Highlights

The following are some key points regarding RSV protection for infants:

Infant Monoclonal Antibody:

• Beyfortus® is indicated for infants born during or entering their first RSV season and for children up to 24 months of age who remain vulnerable to severe RSV through their second RSV season.

• Enflonsia® is indicated for infants born during or entering their first RSV season.

Maternal RSV Vaccination:

• Abrysvo® is the only RSV vaccine recommended for pregnant individuals.

• CDC recommends one dose of Abrysvo® for individuals who are 32 0/7 weeks through 36 6/7 weeks gestation.

• In most of the continental United States, pregnant individuals should receive RSV vaccine from September (1–2 months before the anticipated start of RSV season) through January (2–3 months before the anticipated end of the RSV season) so that their babies are protected against severe RSV disease at birth.

• At this time, if a pregnant individual has already received a maternal RSV vaccine during any previous pregnancy, CDC does not recommend another dose of RSV vaccine during subsequent pregnancies. If the birthing parent was ***not*** vaccinated during the ***current*** pregnancy, the infant should receive nirsevimab during October–March (ideally, in October if born during April–September or at birth if born during October–March).

• If the birthing parent received RSV vaccination within 14 days of delivery, then it is recommended that all infants born during RSV season or entering their first RSV season receive one dose of an RSV monoclonal antibody.

Resources & Support

MS Division of Medicaid — Office of Pharmacy:
Pharmacy - Mississippi Division of Medicaid

MANP
MISSISSIPPI ASSOCIATION of NURSE PRACTITIONERS

National Nurse Practitioner Week
NOVEMBER 9-15, 2025

On Tuesday, September 9, the MS Association of Nurse Practitioners met with Governor Tate Reeves for the official signing of a proclamation recognizing National Nurse Practitioner Week, which will be observed November 9–15, 2025.

(Pictured Left-Right, Dr. Shonda Phelon, PMHNP, AANP State Liaison; Dr. Carolyn Coleman, PMHNP, MANP Board Director; Dr. Toni Marchionna, NP, MANP Board Secretary; Gov. Tate Reeves; Dr. Wanda Stroupe, FNP, MANP President; Dr. Tina Highfill, FNP, MANP Executive Director)

Quick Notes
Vitamin D Assay Testing

The College of American Pathologists (CAP) collaborates with laboratories worldwide to enhance the quality of laboratory-related medicine and promote the best patient care.[1] According to Rita Khoury, MD, laboratory director of Aculabs in East Brunswick, New Jersey, there have been increasing inappropriate orders for Vitamin D testing in the US.[2] Specifically noting two predominant tests, the 1,25-dihydroxy test and the 25-hydroxy (25-OH) test. [2]

The 1,25-dihydroxy test should only be used for patients who have hypercalcemia, granulomatous diseases, chronic kidney failure, or hyperparathyroidism. 1,25-dihydroxy vitamin D is primarily regulated by the parathyroid hormone levels, which are regulated by calcium and vitamin D. In cases of vitamin D deficiency, 1,25-dihydroxy vitamin D levels elevate not decline. Also, this is not an in-house test for most labs and requires a special send-out. The cost of 1,25-dihydroxy vitamin D tests is approximately twice as much as 25-hydroxy (25-OH) test. It also takes longer testing time, which can delay care.

Dr. Khoury told Medscape Medical News that her team found 10,722 25-OH tests in 2011, which is now up to more than 26,000 a year in 2025.[2]

Some of the increase in inappropriate testing is thought to be contributed to a lack of understanding of the two tests and possibly an error by either the provider or staff when searching for "Vitamin D" tests in an electronic system, where the 1,25-dihydroxy test is prepopulated in a dropdown first. Experts also report an increase in online lab ordering from 12.1% in 2011 to over 98% by 2023.

Local Coverage Determination (LCD) published by Centers for Medicare & Medicaid Services (CMS) advises that 25-OH vitamin D test better reflects the sum total of vitamin D produced endogenously and absorbed from the diet than does the level of the active hormone 1,25-dihydroxy vitamin.[3] 25-OH vitamin D testing will be considered medically reasonable and necessary for individuals at risk for deficiency with the specified conditions listed in Vitamin D Assay Testing. [3]

Deficiency of 1,25-dihydroxy vitamin D does not necessarily reflect deficiency of 25-OH vitamin D, and its measurement should be limited to specific clinical situations;

- Unexplained hypercalcemia
- Unexplained hypercalciuria
- Suspected genetic childhood rickets
- Suspected tumor-induced osteomalacia
- Nephrolithiasis
- Renal osteodystrophy
- Sarcoidosis

In recent years, although providers feel the need to repeat testing for Vitamin D deficiencies or to monitor treatment, most payers follow CMS guidelines for the reasonable frequency of testing. For services performed on or after 07/27/2023, CMS has determined that once a beneficiary is vitamin D deficient with a serum level of <30 ng/ml, a repeat test after 12 weeks of supplementation will be considered reasonable and necessary to ensure adequate replacement has been accomplished. The medical record must reflect that the beneficiary has been compliant with supplementation. A serum level of ≥30 ng/ml will be considered evidence of adequate replacement, and no further testing is necessary.[3]

If, after a 12-week period of supplementation and documentation of compliance with the prescribed supplementation, the serum level is still <30 ng/ml, one (1) additional repeat testing within a rolling 12-month period of the initial test may be performed.[3]

Thereafter, annual testing may be appropriate depending upon the indication and other mitigating factors. The documentation must support the need for annual testing. Annual testing should be rare.[3]

References

1. https://www.cap.org/laboratory-improvement
2. https://www.medscape.com/viewarticle/orders-wrong-vitamin-d-test-rising-2025a1000o2b
3. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=39391

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Join us today & make your voice heard.

Our actions and decisions today will shape the way we will be living in the future.

MANP

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https://www.msanp.org/home

MS Association of Nurse Practitioners' key initiatives include

- We advocate for NPs with policymakers, and other healthcare entities both in the state and nationally
- Full Practice Authority allows NPs to practice to the fullest extent of their education and training *without* expanding their respective scopes of practice
- Increase access to care for patients across Mississippi
- NP orders for durable medical equipment and devices
- NP signature recognition on legal documents and eliminating co-signatures by physicians
- NP Income tax incentives & exemptions for underserved practice areas & NP owned businesses
- NP reimbursements and inclusion in insurance networks
- Recognize NPs as primary care providers (PCP)
- Increased faculty salaries

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Contact MS Association of Nurse Practitioners, 1888 Main St, Suite C312, Madison, MS 39110 email: msanp@msanp.org